TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
UNITED REGIONAL MEDICAL CENTER

Respondent Name
CITY OF WICHITA FALLS

MFDR Tracking Number
M4-17-3295-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 11, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The hospital has set up a consistent set of criteria that is used in all ED level determination. I have included the outline of those criteria as well as medical records ..."

Amount in Dispute: $979.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Emergency Room record does not support the presenting problem was of high severity."

Response Submitted by: STARR Comprehensive Solutions

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 30, 2016	Emergency Room Visit	$979.00	$556.34

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
   - W3 – Additional reimbursement made on reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - P14 – The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 150 – "Payment adjusted because the payer deems the information submitted does not support this level of service."

   The respondent asserts that "The Emergency Room record does not support the presenting problem was of high severity."

   The requestor argues that "The hospital has set up a consistent set of criteria that is used in all ED level determination. I have included the outline of those criteria as well as medical records ..."

   The disputed services include emergency department visit evaluation and management code 99284, which by definition requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Review of the medical record finds a detailed history taken, a detailed examination documented, and medical decision making of *high* complexity, involving review of CT scan results, review of 4 current medications, ordering administration of 3 additional medications, and assignment of six diagnoses.

   The code definition states that "Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function." However, while this may "usually" be the case, it is not a required element of the definition. It is not necessary for the presentation to be of high severity for the service to meet the definition so long as the three required key components are documented. Consequently, the insurance carrier has denied using an inappropriate standard that is not a requirement of the code's definition.

   Even so, the documentation does support that the patient presented with pain rated at a 7 out of 10, which is considered "severe pain." Moreover, the pre-hospital care report documents the patient had been brought in by ambulance after being unable to get up from the floor since the prior evening (almost 1 whole day) after the patient's back gave out. The documentation certainly supports a presentation of high severity. In the view of the division, this is exactly the kind of problem that requires urgent evaluation by a physician.

   Upon review of the evidence presented to MFDR, the insurance carrier has failed to present persuasive evidence supporting their reason for denial of the disputed service. The division finds the carrier's denial code is not supported. The health care provider has presented convincing evidence that the documentation supports the services as billed. Accordingly, the services will be reviewed for additional payment according to applicable division rules and fee guidelines.

2. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, which requires the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount (including outlier payments) applying the effective Medicare Outpatient Prospective Payment System (OPPS) formula and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare OPPS formulas and factors are available from http://www.cms.gov.

   Rule §134.403(f)(1) requires the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent, unless a facility or surgical implant provider requests separate payment of implantables. Separate reimbursement for implantables was not requested.

3. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and for services without procedure codes is packaged into the APC payment. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 96374 has status indicator S, denoting significant outpatient procedures, not subject to reduction, and is assigned APC 5693. The OPPS Addendum A rate is $92.40. This is multiplied by 60% for an unadjusted labor amount of $55.44, which is multiplied by the facility wage index of 0.9048 for an adjusted labor amount of $50.16. The non-labor portion is 40% of the APC rate, or $36.96. The sum of the labor and non-labor portions is $87.12. The cost of services does not exceed the fixed threshold of $3,250. The outlier payment is $0. The Medicare facility specific amount of $87.12 is multiplied by 200% for a MAR of $174.24.
   - Procedure code 72131 is assigned APC 5570. The OPPS Addendum A rate is $112.49. This is multiplied by 60% for an unadjusted labor amount of $67.49, multiplied by the facility wage index of 0.9048 for an adjusted labor amount of $61.06. The non-labor portion is 40% of the APC rate, or $45.00. The sum of the labor and non-labor portions is $106.06. The cost of services does not exceed the fixed threshold of $3,250. The outlier payment is $0. The Medicare facility specific amount of $106.06 is multiplied by 200% for a MAR of $212.12.
   - Per Medicare policy, procedure code 96372 may not be reported with procedure code 96374 billed on the same claim. Reimbursement for this service is included with payment for the primary procedure.
   - Procedure code 99284 represents an emergency room visit and is assigned APC 5024. The OPPS Addendum A rate is $326.99. This is multiplied by 60% for an unadjusted labor amount of $196.19, multiplied by the facility wage index of 0.9048 for an adjusted labor amount of $177.51. The non-labor portion is 40% of the APC rate, or $130.80. The sum of the labor and non-labor portions is $308.31. The cost of services does not exceed the fixed threshold of $3,250. The outlier payment is $0. The Medicare facility specific amount of $308.31 is multiplied by 200% for a MAR of $616.62.
   - Procedure codes J2270 and J3360 have status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.

4. The total recommended reimbursement for the disputed services is $1,002.98. The insurance carrier has paid $446.64, leaving an amount due to the requestor of $556.34. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $556.34.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $556.34, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	July 28, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.